STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005033	A. BUILDING _____ B. WING _____	08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER REGIONAL HOSPITAL	85 EAST US HWY 6 VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of two State hospital complaints. Complaint Number: IN00090284 Unsubstantiated: lack of sufficient evidence Complaint Number: IN00090294 Unsubstantiated: lack of sufficient evidence Date: 8/24/11 Facility Number: 005033 Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor Porter Valparaiso Hospital is in compliance with 410 IAC 15-1.5-6, Nursing service, 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules. QA: claughlin 09/14/11	S 000		